## 2012 LIST OF NORDHOFF CHIROPRACTIC OFFICE FORMS

<table>
<thead>
<tr>
<th>FORM #</th>
<th>DESCRIPTION</th>
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<tr>
<td><strong>MISCELLANEOUS FILES</strong></td>
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<tr>
<td>900</td>
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<td>Headache-Migraine Questionnaire</td>
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<td>ADL-Functional Capacity Form</td>
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<td>3805</td>
<td>Medicare subluxation documentation form</td>
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<td>1080</td>
<td>Symptom Intensity &amp; Frequency Form</td>
<td>3810</td>
<td>Medicare progress notes</td>
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<tr>
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<td>Before &amp; After Injury Comparison Form</td>
<td>3815</td>
<td>Treatment Plan and Discharge Summary</td>
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<td>Pain Intensity NAS Scale (0-10) Not colored</td>
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<td>Back of Travel Card-Report of findings</td>
<td>4010</td>
<td>Motor Vehicle Crash Form (3 pages)</td>
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<td>SOAP Notes (complex case)</td>
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<td>Motorcycle Injury Form (2 pages)</td>
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<td>1530</td>
<td>Progress Notes</td>
<td>4110</td>
<td>Bicycle Injury Form (2 pages)</td>
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<td>Disability Form (General)</td>
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<td>Pedestrian Injury Form (2 pages)</td>
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<td>List of All Providers Seen (3 pages)</td>
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<td>Slip-and-Fall Injury Form</td>
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<tr>
<td>2200</td>
<td>Patient Home Instructions</td>
<td>4200</td>
<td>Doctor’s Lien DC/MD (1 &amp; 2 pages)</td>
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<td>2210</td>
<td>Post Injury Instructions</td>
<td>4210</td>
<td>Lien Reduction Letter to Attorney</td>
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<td>Notice of PI Case Closure to Insurance Co</td>
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<td>Disc Protrusion and Spinal Stenosis</td>
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<td>Risk Factors for Nontraumatic Back Pain</td>
<td>4400</td>
<td>PI Physician Progress Report (2 pages)</td>
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<td>Prescription for Gym Exercise Trainer</td>
<td>4450</td>
<td>Motor Vehicle Collision Injury Report</td>
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<td>Prescription for Massage Therapy</td>
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<td>Case Worksheet for Deposition/Trial</td>
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GENERAL HEALTH HISTORY (Page 1)

DESCRIBE ALL OF THE REASON(S) WHY YOU HAVE COME TO OUR OFFICE (Symptoms/Injury). Print Clearly

Check no or yes to the questions below. If yes, check if you have it presently or had the condition in the past.

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
<th>GENERAL QUESTIONS</th>
<th>PAST</th>
<th>PRESENT</th>
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<tr>
<td></td>
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<td>History of poor healing or told that you have a healing disorder?</td>
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<td>Smoke cigarettes or use tobacco products?</td>
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<td>History of thyroid, kidney, liver/gallbladder, pancreas, or other endocrine-metabolic disorder?</td>
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<td>Have you been told you are pre-diabetic (hypoglycemia), diabetic or have high cholesterol?</td>
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<td>Heart attack, heart disease or do you have a heart pacemaker or neck or chest shunt?</td>
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<td>History of infectious diseases such as AIDS, Tuberculosis, Meningitis, Hepatitis, etc.?</td>
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<td>Do you have difficulties or intolerance to heat packs or ice packs on your skin?</td>
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<td>Do you have problems with dizziness, blacking out, balance problems, fainting, or tripping?</td>
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<td>Epilepsy-Seizure-Convulsion history or any other neurological disease?</td>
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<td>History of multiple sclerosis, lupus, psoriasis, paralysis, or disease affecting nerves?</td>
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<td>Cancer history or cancer treatment or surgery of any type?</td>
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<td>Stroke history (Indicate any suspected mild strokes or transient ischemic attacks-TIA)?</td>
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<td>Blood clots, bleeding or vascular disorder, or told you have an abdominal or brain aneurysm?</td>
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<td>Hypertension or high blood pressure? If yes, name of MD seeing:</td>
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<td></td>
<td>Autoimmune disease, digestive or intestinal disease, or respiratory diseases, etc?</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>History of fatigue, weight loss/gain, fever, kidney/ovarian pain, or bowel/bladder disorders</td>
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<tr>
<td></td>
<td></td>
<td>Women only: Check box to left if there any chance that you are currently pregnant</td>
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</tbody>
</table>

If you checked yes, please describe:

HAVE YOU HAD PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN?
☐ NO, ☐ YES. (Check NO box if you have never had a history in the past) If yes, please describe below:

HAVE YOU HAD FRACTURES/BROKEN BONES IN THE PAST?
☐ NO, ☐ YES. (Check NO box if you have never had any broken bones in the past). If yes, please describe below:

HAVE YOU EVER BEEN HOSPITALIZED?
☐ NO, ☐ YES. (Check NO box if you have never been hospitalized in the past) If yes, please describe below:

HAVE YOU HAD ANY PREVIOUS SURGERIES?
☐ NO, ☐ YES. (Check NO box if you never had any surgical procedure in the past). If yes (including silicone implants, cancer, spine, herniated discs, genetic conditions, ports in the chest/abdomen). Please describe the type and dates:

Patient Name: Sally Jones | Date: 11-11-11 | Doctor: Lawrence Nordhoff, DC

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### GENERAL HEALTH HISTORY (Page 2)

**PRIOR INTERVENTION BY OTHER HEALTH CARE PROVIDERS**

- □ No, □ Yes. **Have you seen any other doctors for the same condition(s) that you are seeking chiropractic today?**
  
  If yes, list doctor names, tests, and results:

- □ No, □ Yes. **Have you taken any pain or anti-inflammatory medications today?** If yes, describe the name(s) of the medication(s) and when you took it last:

- □ No, □ Yes. **Have you recently had or do you currently have a fever, cold, virus, or infection?** If yes, describe:

- □ No, □ Yes. **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, rheumatoid arthritis, collagen disorders, hypermobility, other forms of joint or spine arthritis, herniated discs in the spine, spinal cord disease, brain disease, nerve disease, blood vessel aneurysms, blood disease, or other diseases?
  
  If yes, please describe:

- □ No, □ Yes. **Have you been treated by a Chiropractor for any condition and/or injury in the past?**
  
  List Chiropractor’s Name: ____________________________
  City: ____________________________ Year: ______________
  List Problem(s) for which the Chiropractor treated you:

  **Please list the name of your primary medical doctor and when you had your last appointment?**

- □ No, □ Yes. **Do you have any problems lying face down on an examination table?** (tender breasts, chest or breast surgical implants, ports, etc)? If yes, why: ______________________________________________________

**SLEEPING PATTERNS AND/OR DISORDERS**

- □ No, □ Yes. **Do you sleep normally at night?** If no, please describe your sleeping problems below:

**MEDICATION USE CURRENTLY (PRESCRIBED AND OVER-THE-COUNTER)**

- □ No, □ Yes. **Currently, are you taking any medications?** In yes, list all medications that you are taking:

**FOOD OR MEDICATION ALLERGY HISTORY**

- □ No, □ Yes. **Do you have allergies to any medications, foods, shellfish, seafood, etc?** If yes, List:

**NUTRITION-DIET**

- □ No, □ Yes. **Recently, do you consider that your usual diet is good and well balanced?**
  
  If you are anemic, bruise easily, or have a poor diet please describe:

**EXERCISE ROUTINE**

- □ No, □ Yes. **Do you exercise every week?** If yes, describe your typical routine over the past month.

---

Patient Name: Sally Jones  
Date: 11-11-11  
Doctor: Lawrence Nordhoff, DC

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**GENERAL SPINE HISTORY (HEAD, NECK, BACK, SACRUM, AND PELVIS)**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Have you been told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have you been told that you have a bulging/herniated disc or disc degeneration in the spine?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have you been told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis in your spine or joints?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have you been told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have you had a previous head injury or brain/spinal cord disease in the past?</td>
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<tr>
<td></td>
<td></td>
<td>Have you injured your neck, back, sacrum or pelvis in the past?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have you ever had an injection into your discs or spine (facet joints) in your back, sacrum or neck?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do you have a stomach, intestinal, digestive, malabsorption disorder (wheat allergy, etc.), muscle disease, prostate, ovarian, or uterine problem, condition or disease that could be affecting your back?</td>
</tr>
</tbody>
</table>

If yes, describe and provide dates:

---

**SYMPTOM OR COMPLAINT ONSET**

- **Suddenly**, □ Gradually. Check box indicating if your current neck/back symptoms developed gradually or suddenly.

**NECK PAIN AND/OR INJURY HISTORY**

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe your neck pain location (left side, right side, middle of your neck, both sides, front, or back).</td>
</tr>
<tr>
<td>When did your neck pain begin and/or injury occur?  Date required:</td>
</tr>
<tr>
<td>Describe how or why your pain began (mechanism). Describe any neck injury (what happened)?</td>
</tr>
<tr>
<td>Describe all aggravating physical activities/motions. What makes your neck or referring arm pain worse?</td>
</tr>
<tr>
<td>Describe any relieving physical activities. What activities lessen your neck/arm symptoms?</td>
</tr>
<tr>
<td>Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff, etc).</td>
</tr>
<tr>
<td>Describe any symptoms that originate from your neck that radiate to your head/shoulders/arms/hands.</td>
</tr>
<tr>
<td>How frequent/severe are your pain/symptoms?  Percent of time %. Pain Severity (0-10)</td>
</tr>
<tr>
<td>List all doctors you have seen for your neck before.</td>
</tr>
</tbody>
</table>

**NECK REGION RECENT HISTORY (Check following)**

- Recently, have you had blurry or double vision, trouble speaking/swallowing, dizziness, fainting spells, nausea, trouble walking or balance problems, or hand/feet numbness or weakness?
- Do you black out, lose your balance or get a headache when you look up or twist your head?
- Do you feel your neck pain sends pain downward between your shoulders or to the front of your chest?
- Have you recently had a new type of headache or an unusually severe headache?
- Have you recently noticed your head leaning or tilting to one side?
## UPPER BACK, LOW BACK, SACRUM, PELVIS REGION HISTORY (Page 4)

<table>
<thead>
<tr>
<th>Question</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Describe your pain location (middle back, lower back, sacrum and if located in the front/side/back of body).</td>
<td></td>
</tr>
<tr>
<td>When did your pain begin and/or injury occur?</td>
<td>Date required:</td>
</tr>
<tr>
<td>Describe how or why your pain began (mechanism).</td>
<td></td>
</tr>
<tr>
<td>Describe any injury (what happened)?</td>
<td></td>
</tr>
<tr>
<td>Describe all aggravating physical activities/motions.</td>
<td></td>
</tr>
<tr>
<td>What makes your back or referring leg pain worse?</td>
<td></td>
</tr>
<tr>
<td>Describe any relieving physical activities.</td>
<td></td>
</tr>
<tr>
<td>What activities lessen your back or leg symptoms?</td>
<td></td>
</tr>
<tr>
<td>Describe any symptoms that originate from your back that radiate to your chest, hips, legs, or feet.</td>
<td></td>
</tr>
<tr>
<td>Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff, etc).</td>
<td></td>
</tr>
<tr>
<td>How frequent are your pain/symptoms (Percent)?</td>
<td></td>
</tr>
<tr>
<td>How severe are your pain/symptoms (Zero-to-10)?</td>
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</tr>
<tr>
<td>List all doctors you have seen in the past for your back.</td>
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### UPPER BACK AND LOW BACK REGION HISTORY CONTINUED

<table>
<thead>
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<th>Question</th>
<th>Details</th>
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<tbody>
<tr>
<td>Do you have pain that shoots or radiates outward along your rib cage?</td>
<td></td>
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<tr>
<td>Does your middle or upper back or chest wall pain intensify when you take in a deep breath or cough?</td>
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<tr>
<td>Do you sometimes have a tight band-like feeling around your chest?</td>
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<tr>
<td>Have you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?</td>
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</tr>
<tr>
<td>When you move your neck around, does your middle back pain or chest pain increase?</td>
<td></td>
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<tr>
<td>When you cough, sneeze, or bear down to have a bowel movement, does your back/leg pain get worse?</td>
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<tr>
<td>Do you have a consistent pattern of getting severe leg pain or cramping after walking for similar distances that is relieved by resting or sitting down?</td>
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<tr>
<td>Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down?</td>
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<tr>
<td>Does either leg or foot drag on the floor when you walk?</td>
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<tr>
<td>Have you recently had a lot of leg cramps at night?</td>
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<tr>
<td>Are you taking a calcium or other dietary supplements to help your leg cramps?</td>
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</tr>
<tr>
<td>Have you recently had any urinary or bowel incontinence or had difficulty urinating?</td>
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<tr>
<td>Have your feet felt cold recently? If yes, indicate which foot or if both feet:</td>
<td></td>
</tr>
<tr>
<td>Have you recently noticed that either of your legs occasionally gives out on you when you walk?</td>
<td></td>
</tr>
<tr>
<td>Have you recently felt weakness in one or both of your legs?</td>
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</tr>
<tr>
<td>Has your anal-rectal region been completely numb recently?</td>
<td></td>
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</tbody>
</table>

Please print clearly

If yes, describe and indicate dates:

<table>
<thead>
<tr>
<th>Patient Name: Sally Jones</th>
<th>Date: 11-11-11</th>
<th>Doctor: Lawrence Nordhoff, DC</th>
</tr>
</thead>
</table>
## Extremity Pain or Injury Questionnaire

Please answer the following sections that apply to you. If some of the questions are unclear to you, skip ahead to the next question. Your doctor will be going over this questionnaire with you. Please print clearly.

### Shoulder, Arm, Elbow, Wrist and Hand Region

<table>
<thead>
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<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Describe pain location (left, right, middle, front, back, top). Example: top of shoulder joint/inside left elbow</td>
<td></td>
</tr>
<tr>
<td>When did your pain begin and/or injury occur?</td>
<td>Date required:</td>
</tr>
<tr>
<td>Describe how or why your pain began (mechanism).</td>
<td></td>
</tr>
<tr>
<td>Describe any injury (what happened)?</td>
<td></td>
</tr>
<tr>
<td>Describe all aggravating physical activities/motions.</td>
<td></td>
</tr>
<tr>
<td>What makes your shoulder-arm symptoms worse?</td>
<td></td>
</tr>
<tr>
<td>Describe any relieving physical activities/motions.</td>
<td></td>
</tr>
<tr>
<td>What lessens your shoulder-arm pain-symptoms?</td>
<td></td>
</tr>
<tr>
<td>If present, describe which fingers or part of your hand have any pain, numbness, or tingling.</td>
<td></td>
</tr>
<tr>
<td>Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff, etc).</td>
<td></td>
</tr>
<tr>
<td>How frequent are your pain/symptoms (Percent)?</td>
<td></td>
</tr>
<tr>
<td>How severe are your pain/symptoms (Zero-to-10)?</td>
<td></td>
</tr>
<tr>
<td>List all doctors you have seen in the past for your shoulder, arm, and/or hands.</td>
<td></td>
</tr>
</tbody>
</table>

### Hip, Leg, Knee, Ankle and Foot Region

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe your pain location (left, right, middle, front, back). Example: front of hip/outer calf area.</td>
<td></td>
</tr>
<tr>
<td>When did your pain begin and/or injury occur?</td>
<td>Date required:</td>
</tr>
<tr>
<td>Describe how or why your pain began (mechanism).</td>
<td></td>
</tr>
<tr>
<td>Describe any injury (what happened)?</td>
<td></td>
</tr>
<tr>
<td>Describe all aggravating physical activities/motions.</td>
<td></td>
</tr>
<tr>
<td>What makes your hip-leg pain-symptoms worse?</td>
<td></td>
</tr>
<tr>
<td>Describe any relieving physical activities:</td>
<td></td>
</tr>
<tr>
<td>What lessens your hip-leg symptoms-pain?</td>
<td></td>
</tr>
<tr>
<td>If present, describe which toes or part of leg/foot have pain, numbness, or tingling.</td>
<td></td>
</tr>
<tr>
<td>Describe how your symptoms feel (examples: dull, sharp, ache, numbness/tingling, stiff, etc).</td>
<td></td>
</tr>
<tr>
<td>How frequent are your pain/symptoms (Percent)?</td>
<td></td>
</tr>
<tr>
<td>How severe are your pain/symptoms (Zero-to-10)?</td>
<td></td>
</tr>
<tr>
<td>List all doctors you have seen in the past for your hip, leg, knee, ankle, and/or foot.</td>
<td></td>
</tr>
</tbody>
</table>

☐ No, ☐ Yes. **Have you had any prior injuries or fractures to your arms and legs?**

Describe body part, date, and residual pain:

---

Patient Name: Sally Jones | Date: 11-11-11 | Doctor: Lawrence Nordhoff, DC

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Chiropractors have been providing great health care services to patients for more than 100 years. Many patients with acute and chronic spine-related and extremity disorders and joint stiffness, arm and leg complaints, and other musculoskeletal conditions or injuries have benefited by having chiropractic care. In order for said chiropractor (see below) to determine what types of treatment may be beneficial to you, it is necessary to perform a physical examination of your spine and other joints. Identifying subluxations or abnormal joint function is achieved by looking at x-rays and/or during the examination which involves moving various joint(s) or areas of your body in specific directions to determine how well each of the painful or restricted joints or bony structures of your body moves or is positioned when compared to the normal population. Spinal manipulation, a procedure that involves the application of controlled mechanical forces to specific joint structures, has the goal of improving and restoring normal joint motion of the spine and other joints. Better bone and joint alignment and motion improves the function and health of the joint, associated muscles and nerves and thus reduces inflammation and related symptoms. After treatment, most of our patients experience increased flexibility, feel less pain and other symptoms, and are able to return to their normal physical activities at work and home. The goal of chiropractic care is to improve and normalize the quality of joint motion in the affected areas of your body, to encourage you to adopt good lifestyle habits such as exercise and good nutrition, and assist you during the recovery process.

Rejecting chiropractic care may lead to progression of joint restrictions, stiffness, pain and other symptoms and may compromise your ability to perform activities at home and work. There are various types of non-chiropractic treatment available for patients who have your type of condition(s), including; acupuncture, physical therapy, or from a medical doctor or other health care provider. While uncommon, some patients may experience short-term increase of pain and other symptoms or muscle and ligaments strains or sprains as a result of manipulation and manual therapy techniques such as joint mobilization or deep massage. There are some rare potential serious bodily harm risks to chiropractic manipulations and procedures to various regions of the body, including, but not limited to, strains, sprains, fractures, disc injuries, dislocations, strokes, and nerve injuries.

Strokes are a very rare event in the general population and have been reported after patients visit chiropractors or primary care providers (medical doctors). Scientific evidence shows that the increased stroke risks are likely due to patients seeking care from chiropractors or medical doctors because of an unusual type or severity of headache and neck pain. These symptoms are from an early stroke that is already occurring and progressing from prior damage to an artery in the neck. Once seen by a doctor, the risk of the stroke progressing has been found in the literature to be similar (no excessive risk) for patients who are seen by chiropractors and primary care providers. There is scientific evidence that shows that patients who have these developing strokes may have weakened or diseased artery vessel walls that are particularly vulnerable to a variety of motions or movements of the neck and head or they may occur spontaneously without any known reason. Research has shown that there are many stroke risk factors, including: disease of blood vessels, high blood pressure, birth control pills, environmental and genetic factors, infections, occurring during falls, violent car accidents, coughing/sneezing, sport activities, or even during such trivial movements as turning ones head to back up a car or to paint a ceiling. The literature shows that there are rare risks of strokes specifically from rotating and extending the head and neck during cervical spine manipulation or other maneuvers that rotate or extend the head and neck, particularly the upper cervical spine. You are being informed of this reported association because a stroke may cause serious injury or even death.

I voluntarily consent to the performance of chiropractic examination, manipulation and other chiropractic procedures, on myself, (or on the patient named below, for whom I am legally responsible) by said chiropractor (see below), his/her preceptor(s), and/or other licensed doctors of chiropractic who now or in the future provide chiropractic treatment for me. This consent includes other doctors of chiropractic that are employed by, associated with, or serve as back-up for said chiropractor, whether or not their names are listed on this form. I understand that the results from the chiropractic treatment are not guaranteed for my condition. The doctor has verbally discussed the goals and potential benefits of the proposed treatment, other alternative types of treatment for my condition and the associated risks by having chiropractic examination, manipulation, and other procedures. I have had the opportunity to read this form and understand the above statements, accept the risks mentioned, and hereby consent and agree to the recommended chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment.

DR SIGNATURE: CONSENT WAS DISCUSSED VERBALLY.

DR SIGNATURE: PATIENT WAS ASKED “DO YOU UNDERSTAND?”

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

NAME: ____________________________ RELATIONSHIP ____________________________

Indicate your name and relationship (parent/guardian/personal representative) if signing for patient (minor):

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Lawrence Nordhoff, DC, 4133 Mohr Ave, Ste F, Pleasanton CA 94566 Phone 925-484-2928

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# PATIENT PROGRESS NOTES

<table>
<thead>
<tr>
<th>DATE</th>
<th>S</th>
<th>See Pain Drawing. □ H/A, □ Nk pn, □ MB pn, □ LBP, □ SI pn, □</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O</td>
<td>Pain-Tenderness with palpation:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Asymmetry</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ROM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tissue Tone Abnormalities</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>□ Responding (Normally/Slowly/No improvement). ADLs/Function</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>□ See _____ times a week/mo. □ See PRN.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Cerv tract ___ min ___ lbs, □ Muscle Stim ___ min, □ Ice, □</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ CMT: □ Nk ____, □ MB ____, □ LB ____, □ SI, Other: __________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Mobilization □ Nk, □ MB, □ LB, □ SI, Other:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Myotherapy _____ min (gentle/deep) to areas noted in objectives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Therapeutic Exercises ____ min/Neuromuscular reeducation ____ min:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frequency of future treatment: □ will continue as set in initial plan, □ frequency changed (explain):</td>
</tr>
</tbody>
</table>

These have 2 dates per page.

# CMS-MEDICARE PATIENT PROGRESS NOTES

<table>
<thead>
<tr>
<th>DATE</th>
<th>S</th>
<th>Pain Intensity (0-10). __________ Pain levels: (better/same/worse than last visit) List ADL functional activities that are better/same/worse.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Manipulation □ Acute Treatment 98940-AT 98941-AT □ Maintenance Care 98940-GA Non-Manipulation □ -GY -GZ</td>
<td></td>
</tr>
<tr>
<td></td>
<td>O</td>
<td>Pain-Tenderness with palpation:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Asymmetry</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ROM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tissue Tone Abnormalities</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>Asses change in pts condition (function, posture, etc) Patient response to manipulation: (better/same/worse)</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>CMT to _____________________________ subluxations. □ Mobilization □ Nk, □ MB, □ LB, □ SI, Other:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Myotherapy (gentle/deep) to areas noted in objectives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Therapeutic Exercises ____ min/Neuromuscular reeducation ____ min:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frequency of future treatment: □ will continue as set in initial plan, □ frequency changed (explain):</td>
</tr>
</tbody>
</table>
# MOTOR VEHICLE COLLISION FORM

**Patient Name:** ___________________________________________

**Date of crash:** ___________________________  **Time of collision:** ___________________________  □ AM  □ PM

**City where crash occurred:** ___________________________  **Was the street wet or dry?** □ Wet  □ Dry

**Street (location) where crash occurred:** __________________________________________________________

**Who owns the vehicle in which you were hit?** _________________________________________________

**What is the estimated repair damage to your vehicle?** $___________  □ Unknown, □ Estimate not done yet

**How many people were in your vehicle at the time of the crash?** ___________

**Did the police come to the crash scene?** □ Yes, □ No

**Did the police make a written report?** □ Yes, □ No

**Were any photographs taken of the vehicles?** If yes, who took them?

## DESCRIBE HOW THE CRASH HAPPENED


## COLLISION DESCRIPTION-TYPE

*Check all that apply to you. Indicate which type of automobile crash you were involved in:*

<table>
<thead>
<tr>
<th>☐ Single-vehicle crash</th>
<th>☐ Two-vehicle crash</th>
<th>☐ Three-or-more vehicles</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Rear-end crash</td>
<td>☐ Side crash</td>
<td>☐ Rollover</td>
</tr>
<tr>
<td>☐ Head-on or frontal crash</td>
<td>☐ Hit guard rail, tree, or object</td>
<td>☐ Ran off the road</td>
</tr>
<tr>
<td>☐ Other (Describe):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## CIRCLE YOUR SEATING POSITION

*The number’s 1-9 indicate where you were seated at the time of the crash. The #1 spot is the driver. Seating numbers 7-9 are for a third row seat.*

![Seating Positions Diagram]

<table>
<thead>
<tr>
<th>Front of Vehicle</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

| Rear of Vehicle |

## DURING AND AFTER THE CRASH, YOUR VEHICLE:

| ☐ Kept going straight, not hitting anything | ☐ Kept going straight, hitting car in front | ☐ Was hit by another vehicle | ☐ Spun around, not hitting anything | ☐ Spun around, hitting another car | ☐ Spun around, hitting object/curb other than car |

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INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING:
Please draw lines from the body regions on the left side and match to the right side.

<table>
<thead>
<tr>
<th>BODY REGION</th>
<th>OBJECT YOU HAD CONTACT WITH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head</td>
<td>Windshield or side window</td>
</tr>
<tr>
<td>Face</td>
<td>Steering wheel</td>
</tr>
<tr>
<td>Shoulder</td>
<td>Side of door</td>
</tr>
<tr>
<td>Arm/hand</td>
<td>Dashboard</td>
</tr>
<tr>
<td>Front chest wall</td>
<td>Knee bolster/glove compartment</td>
</tr>
<tr>
<td>Side chest wall</td>
<td>Direct contact with other vehicle (hood)</td>
</tr>
<tr>
<td>Hip/abdomen</td>
<td>Frame/Pillar within vehicle near window</td>
</tr>
<tr>
<td>Knee</td>
<td>Roof or top part of vehicle</td>
</tr>
<tr>
<td>Leg</td>
<td>Another person sitting in your vehicle</td>
</tr>
<tr>
<td>Foot</td>
<td>Other</td>
</tr>
</tbody>
</table>

CHECK IF ANY OF THE FOLLOWING PARTS OF YOUR VEHICLE WERE DAMAGED IN THE COLLISION:
- Windshield
- Steering wheel
- Seat bent or damaged
- Dash or area around knee/foot
- Side or rear window broken
- Other

Describe Damage:

ALL TYPES OF COLLISIONS  Indicate those relevant to your case.
YES  NO

- Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the crash?
- Did the side door, dash, or interior of your vehicle touch or hit your body during the crash?
- Did you strike or did any objects or animals within your vehicle hit you during the crash?
- Was the door(s) of your vehicle damaged to a point where you could not open the door?
- Did an airbag deploy in your vehicle during the crash?  If yes, circle (side airbag/front airbag)
- Did you have any cuts, bruises, or abrasions from the airbag deploying?
- Did your seatbelt system require repairs after the crash?
- Was the back of your seat that your were sitting in damaged or bent during the crash?
- If a side impact, did the front of the other vehicle strike the door next to where you were sitting?

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:
YES  NO

- Were you wearing a seatbelt?  If yes, does your seatbelt have a:  □ Lap and Shoulder Strap,
  □ Automatic shoulder strap with driver needing to manually attach lap belt, □ Lap belt only
- Did you have any portion of your seatbelt positioned behind your chest, back or shoulder.
- Did you have any cuts, bruises, or abrasions from the seatbelts?
- Were you holding onto the steering wheel (driver only) at the time of impact?
  If yes, Indicate where each hand was positioned (*Use time clock face as your reference point*):
  Left hand:  □ Not on wheel, □ Yes, hand at ___ o’clock, □ Hand elsewhere
  Right hand: □ Not on wheel, □ Yes, hand at ___ o’clock, □ Hand elsewhere
REAR-END COLLISIONS ONLY  Answer this section only if you were hit from the rear.

<table>
<thead>
<tr>
<th>Describe your vehicle’s head restraint system:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ movable/adjustable head restraint</td>
</tr>
<tr>
<td>□ no headrests in my vehicle</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Please indicate how your head restraint was positioned at the time of crash (if present):</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ at the top of the back of your head</td>
</tr>
<tr>
<td>□ lower height of the back of your head</td>
</tr>
<tr>
<td>□ level of your shoulder blades</td>
</tr>
</tbody>
</table>

BRUISING AFTER THE CRASH?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Did your body have any bruising (areas that were visibly black, red, and/or blue) after the crash? If yes, indicate where bruising was located on your body and what caused the bruising (if known):

AWARENESS AND BODY POSITION DESCRIPTIONS: Check all areas that apply to you.

| □ you were unaware of the impending collision. You did not see or hear brakes prior to the impact. |
| □ you were aware of the impending crash and relaxed before the collision. |
| □ you were aware of the impending crash and braced yourself. |
| □ your body, torso, and head were facing straight ahead. |
| □ you had your head and/or torso turned at the time of collision: □ turned to left, □ turned to right |
| describe how far you were turned/twisted and why you were turned/what were you doing? |
| □ you were leaning forward at the time of impact resulting in a gap between your body and the seatback. |
| if yes, indicate how far you were leaning and why you were leaning forward? |
| □ your torso/body were positioned normally against the seatback with no gaps due to leaning/twisting. |

HOW SOON DID YOU FIRST NOTICE ANY PAIN/SORENESS AFTER THE CRASH?

Doctor’s Name: Lawrence Nordhoff, DC  Patient’s Name: Sally Jones

Form 4010

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**POST-TRAUMATIC SYMPTOM QUESTIONNAIRE**

**PATIENT INSTRUCTIONS:** It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom listed below does not apply to you.

<table>
<thead>
<tr>
<th>SYMPTOM LIST (Check all that apply to you)</th>
<th>BEGAN IN LESS THAN 24 HOURS AFTER INJURY</th>
<th>BEGAN 1 TO 7 DAYS AFTER INJURY</th>
<th>YOU HAVE SYMPTOMS RECENTLY</th>
<th>HAD SIMILAR SYMPTOMS ONE YEAR BEFORE THIS INJURY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache/migraine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tinnitus (ear ringing)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blurry vision</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memory problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor concentration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea or vomiting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of coordination</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensitivity to sound</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensitivity to light</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of smell</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain/difficulty swallowing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jaw pain/soreness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck pain/soreness/aching/stiff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder pain/stiffness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arm pain/tingling/numbness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrist/hand/finger pain/numbness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in arms/legs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper/middle back pain/soreness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain or bruising</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rib cage pain or bruising</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal-Pelvic pain or bruising</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low back pain/soreness/aching</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip pain or bruising</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper leg or thigh pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg numbness/tingling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain radiating down leg(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower leg or calf pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ankle/foot/toe pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Doctor’s Name: Lawrence Nordhoff, DC  
Patient Name: Sally Jones

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### PROBLEM LIST

- Headaches/Migraines
- Neck pain/soreness/stiffness
- Middle back pain/soreness
- Chest wall pain
- Low back pain/soreness
- Hip/Sacroiliac joint pain
- Knee pain
- Calf/ankle/foot pain
- Rotator Cuff Syndrome
- Shoulder pain
- Elbow/forearm/wrist pain
- Upper extremity pain/paresthesia
- Lower extremity pain/paresthesia
- Radiculopathy
- Biomechanically weak area
- Thoracic Outlet Syndrome
- Carpal Tunnel Syndrome
- Strain
- Sprain
- Strain/Sprain

### ETIOLOGY

- Recent trauma
- Old trauma
- Joint dysfunction
- Post-traumatic inflammation/swelling
- Zygopophyseal joint/capsule irritation
- Facet Joint/Capsule Inflammation
- Spinal stenosis
- Myofascial scar tissue-post traumatic
- Myofascial adhesions, nontraumatic
- Shortening-contracture of muscle
- Active trigger points
- Postural-Ergonomic muscle tension
- Meniscoid entrapment (synovial fold)
- Degeneration of discs
- Degeneration of joints (osteoarthritis)
- Scapular winging, dorsal weakness
- Weak low back/abdominal muscles

### TREATMENT RENDERED

- Spinal adjustments
- Extremity adjustments
- Joint mobilization
- Myotherapy (gentle/deep)
- Joint dysfunction
- Post-traumatic inflammation/swelling
- Zygopophyseal joint/capsule irritation
- Facet Joint/Capsule Inflammation
- Spinal stenosis
- Myofascial scar tissue-post traumatic
- Myofascial adhesions, nontraumatic
- Shortening-contracture of muscle
- Active trigger points
- Postural-Ergonomic muscle tension
- Meniscoid entrapment (synovial fold)
- Degeneration of discs
- Degeneration of joints (osteoarthritis)
- Scapular winging, dorsal weakness
- Weak low back/abdominal muscles

### TREATMENT OBJECTIVES

- Decrease pain/paresthesias
- Enhance and improve repair
- Decrease swelling/inflammation
- Improve and normalize joint motion
- Improve circulation to joint

### NOTES:

________

X-ray necessity:  
- Yes, indicated
- Not indicated. Will wait and observe response first before ordering x-rays.

Complicating factors:  
- None noted
- Yes

Referral for testing or to a MD:  
- None noted
- Yes, indicated

### INITIAL OFFICE VISIT FREQUENCY (ESTIMATE)

- Daily
- 4-5x wk
- 3x wk
- 2x wk
- 1x wk

Daily, 4-5x wk, 3x wk, 2x wk, 1x wk for ___ week(s), then patient will be re-evaluated. Based on exam findings and response to treatment, the visit frequency will then be determined. Will re-evaluate pt in _____ weeks.

- Condition outlined to patient
- Treatment objectives explained
- Pt willing to do home recommendations

Travel Card-Progress Notes Abbreviations:  
- adj = adjustment, MH = moist heat, Elect Stim = Electrical Stimulation, US = Ultrasound, mm = muscle, H/A = headache, Nk pn = neck pain, MB pn = middle back pain, UB pn = upper back pain, SI = Sacroiliac, Sh = shoulder, cerv tract = cervical traction, TP = trigger point, Tx = treatment, ThEx = Therapeutic exercises, MT = manual therapy, Flex-Dist = Flexion-Distraction, Int traction = intersegmental traction, mm = muscle, wk = week.
PROVIDERS SEEN SINCE INJURY OR WHEN CONDITION BEGAN

Start with the first doctor that you went to after your injury or your condition began and list all providers (all types of doctors or therapists), up to your last provider seen, and check all that apply for each. Be certain to list these in sequence from first to last.

1. Name Emergency Room, hospital/doctor/therapist/center: __________________________
   Address: ____________________________________________________________ Date ___________________

Indicate what was done:

- Exam-consultation
- Exam or consult only (no treatment)
- X-ray of neck or head
- X-ray of chest/ribs/middle back
- X-ray of low back/pelvis/hips
- X-ray of shoulder/arms/legs
- MRI/CT scan
- EMG/Nerve conduction study
- Other tests

Indicate if treatment with this provider: □ Helped, □ Did not help, □ Made condition worse

DISABILITY FORM

EMPLOYEE NAME: __________________________ DATE: __________________________

This letter/form certifies that this patient is under my care for the following:

□ Neck or back pain □ automobile crash injury Date: __________________________
□ Knee, leg, or foot pain □ Work related injury Date: __________________________
□ Arm pain □ Sports/Home related injury and/or pain
□ Disc pain □ Other:

HE/SHE IS PRESCRIBED:

□ Temporary Partial Disability (See Modifications) □ Temporary Total Disability □ Permanent Partial Disability (See Modifications) □ Permanent Total Disability

Modifications/Restrictions include the following:

□ Single lifting limited to ______ pounds □ (No/Limited) fingering/handling/grasping
□ No repeated lifting over ______ pounds □ (No/Limited) bending head-neck
□ Lifting restricted to ______ times per hour □ Keyboarding limited to ______ (minutes/hours) per day
□ No lifting above (waist/shoulder/head) level □ Sitting limited to ______ (minutes/hours) per day
□ No raising/lowering objects to other levels □ (No/Limited) carrying activity
□ (No/Limited) bending/stooping waist □ To take a ______ minute break every ______ hours
□ (No/Limited) crouching/squatting □ Allow worker to move about when needed for pain
□ (No/Limited) twisting/pushing/pulling □ Limited to ______ hours of work per day
□ (No/Limited) climbing/crawling □ To wear a ________ (support/brace) at work
□ No (walking/standing) □
□ No prolonged walking/standing □

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ACTIVITIES OF DAILY LIVING RESTRICTIONS-MEDICARE

PATIENT NAME: ____________________________ DATE: ________________

INSTRUCTIONS FOR PATIENTS: Please write in all physical activities for each of the following sections that you are having difficulty performing or that you cannot perform at the time of your initial consultation. The chiropractor needs to identify specific restrictions or disabilities that only relate to your neck, middle back, low back, and pelvic regions. It is important to not include any restrictions or disabilities that you have that relate to other body regions, such as your arms and legs. If not employed please indicate “N/A.” If able to perform all activities in a specific section please indicate “None.” For example: if you do not participate in any sport activities you would indicate “None.”

WORK ACTIVITIES (Please write in all work activities that you have difficulty or inability performing recently):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Which work activity is most difficult to perform: ____________________________

HOME ACTIVITIES (Please write in all home activities that you have difficulty or inability performing recently):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Which home activity is most difficult to perform: ____________________________

RECREATIONAL ACTIVITIES (Please write in all hobby-recreational activities that you have difficulty or inability performing recently):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Which hobby-recreational activity is most difficult to perform: ____________________________

SPORT ACTIVITIES (Please write in all sport activities that you have difficulty or inability performing recently):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Which sport activity is most difficult to perform: ____________________________

Patient Name: ____________________________ Doctor: Lawrence Nordhoff, DC
4133 Mohr Ave, Ste F, Pleasanton, CA 94566

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## SUBLUXATION EXAMINATION FINDINGS

### LEFT SIDE OF BODY

<table>
<thead>
<tr>
<th>Muscle Spasm</th>
<th>Tissue Tone</th>
<th>Range-of-Motion</th>
<th>Asymmetry</th>
<th>Pain Tenderness</th>
<th>LEVEL</th>
<th>Pain Tenderness</th>
<th>Asymmetry</th>
<th>Range-of-Motion</th>
<th>Tissue Tone</th>
<th>Muscle Spasm</th>
</tr>
</thead>
</table>

### RIGHT SIDE OF BODY

<table>
<thead>
<tr>
<th>Muscle Spasm</th>
<th>Tissue Tone</th>
<th>Range-of-Motion</th>
<th>Asymmetry</th>
<th>Pain Tenderness</th>
<th>LEVEL</th>
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<th>Tissue Tone</th>
<th>Muscle Spasm</th>
</tr>
</thead>
</table>

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+ Mild, ++ Moderate, +++ Severe (Findings from Palpation-ROM testing-X-ray). Circled vertebra: indicates subluxation level
FORMULARIO DE INTRODUCCION DEL PACIENTE

<table>
<thead>
<tr>
<th>Nombre del Paciente:</th>
<th>Fecha de Hoy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dirección:</td>
<td>Teléfono de la Casa:</td>
</tr>
<tr>
<td>Ciudad/Código Postal:</td>
<td>Teléfono del Trabajo:</td>
</tr>
<tr>
<td>Fecha de Nacimiento:</td>
<td>Edad:</td>
</tr>
<tr>
<td>Estatura:</td>
<td>Ocupación:</td>
</tr>
<tr>
<td>Peso:</td>
<td>Empleo:</td>
</tr>
<tr>
<td>Licencia de Manejar Num.:</td>
<td>Seguro Social Num.:</td>
</tr>
</tbody>
</table>

**LA VISITA ESTA RELACIONADA CON:**

- [ ] Lesion Relacionada con el Trabajo
- [ ] Lesion Relacionada con la Casa
- [ ] Síntomas Sin Lesiones
- [ ] Lesion por Caída o por Resbalar
- [ ] Lesion de Accidente Automovilístico
- [ ] Lesion por un Deporte
- [ ] Revision General Solamente
- [ ] Exámen Físico requerido por la Escuela

**MUJERES SOLAMENTE**

- [ ] Sí, [ ] No ¿Hay posibilidad que esté embarazada ahora o sospeche estar embarazada?

**INFORMACION DEL SEGURO MEDICO**

- [ ] Sí, [ ] No ¿Tiene usted seguro que cubra un tratamiento Quiropráctico?

Nombre y Dirección de la Compañía de Seguro:

- ¿Es usted el [ ] asegurado, o [ ] dependiente?
- ¿Cuál es el porcentaje que pagan? ____________
- ¿Cuál es la cantidad del deducible? ____________
- ¿Limitan la cantidad de pago por cada visita? ____________
- ¿Limitan el número de visitas? ____________

Nuestra oficina mandará como cortesía la factura a su compañía aseguradora. Si usted tiene una poliza de seguro secundaria, es su responsabilidad mandarles la factura. Tendrá que pagar por todo lo que su compañía de seguros principal no pague. Su segunda compañía aseguradora le pagará después, basado en los beneficios de su poliza.

Si usted lo desea, nuestra oficina le proveerá los servicios para mandar las facturas. *Recuerde que usted es responsable por cualquier cargo incurrido en esta oficina. Es su responsabilidad pagar cualquier deducible, y cualquier otro balance que no sea pagado por su compañía de seguros.*

**PARA DE MANTENER BAJOS LOS GASTOS EN NUESTRA OFICINA Y LAS CUOTAS RAZONABLES, SE REQUIERE EL PAGO AL FINAL DE CADA TRATAMIENTO PARA NUESTROS PACIENTES QUE PAGUEN EN EFECTIVO Y LA PARTE DE PAGO CORRESPONDIENTE PARA LOS PACIENTES REGULARES CON SEGURO MEDICO.**

Firma de la parte responsable (Paciente o Padres): ______________________ Fecha ______________________

*(Doctor’s Name/Address/Telephone)*

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COPYING THE OFFICE FORM FILES ON THE CD INTO AN EXISTING MICROSOFT WORD SOFTWARE IN AN IBM COMPATIBLE COMPUTER.

INSTRUCTIONS: Trying to copy these files by any other means may create margin/tab, page format and font problems. Do not attempt to install these files under the “Run” option or the “Control Panel” option for “Add/Remove” programs. See “HelpForm” file on the CD or on this page in how to copy the files on the CD onto a computers [C] drive. You must already have Microsoft Word (Office 2003 or newer version) program installed and a Windows XP or newer operating system on your IBM compatible computer for these medical forms to copy properly. The tables in these files may not work in Mac-Apple based computers even with IBM compatible software. Once your computer boots up fully, insert the CD into your “Compact Disk” [D:] Drive. If your computer is set up to automatically detect this CD in your computer follow option ‘A’ instructions. If your computer does not automatically detect the CD, then use option ‘B’ copying instructions.

OPTION A. AUTOMATIC CD DETECTION FOR FILE COPYING. If your computer is set on Auto Run when you put a CD in your ‘D’ drive, your computer will automatically detect that you have inserted a CD into the [D:] drive of your computer. After the computer reads this CD, you will see the office forms files that are on the CD listed on your computer screen. Simply click on the “Edit” menu with the left mouse button. Next click on “Select All.” All of the office form files on the CD will become highlighted on your screen. Then click on “Edit” again and then click on “Copy.” The computer will ask you where you want the office form files on the CD copied on your computer’s [C:] drive. Click on “My Documents” and follow the computer prompts to indicate that it is “ok” to copy or paste these office form files to My Documents. Only copy files onto “My Documents.” You also have to option to put all of these files into a separate folder.

OPTION B. MANUAL CD FILE COPYING INSTRUCTIONS. If your computer does not have the automatic run-detection feature turned on in your computer to detect when you insert a CD into the ‘D’ drive, you will have to tell the computer how and where to copy these form files into your existing Microsoft Word program. First, click the left button on your mouse on the “Start” on the bottom left of your computer screen. Next click on “Programs.” Don’t click on “Run.” Next locate and double click on “Windows Explorer.” Your “Windows Explorer” may not be seen at first on your screen and may be listed under “Accessories” and if so you need to click on “Accessories” and then click on “Windows Explorer.” If you have the “Windows Explorer” ICON on your desktop simply double click it with left mouse button. Once your “Windows Explorer” is open look at the top of your screen you will see a directory. Look for and click on “My Computer.” Then look for the heading of “Devices with Removable Storage.” Double click (left button) on your “Disk Drive i.e. [D:]” (Look how your computer is configured for your CD drive location as some computers have ‘E’ drives). You should now see a list of “Files Currently on your ‘D’ Drive” on the right side of your screen. If Dr Nordhoff provided you additional files such as MVCI Seminar notes or on facet and disc you can copy these files onto your computer as well by pressing and holding the “Ctrl” button on your keyboard and clicking the left side of your mouse on each file which should become highlighted. Then release the “Ctrl” button. To copy the selected files you need to go the pull down menu at the top of your screen and click on “Edit” and then click “Copy” next. Before proceeding, look at the top of the screen for the “Address” line and you will see your “D” drive listed. You need to tell your computer that you want copy these files to your hard disc in your computer. You do this by looking to the right of the “Address” for a down arrow and click on the down arrow. You will then need to Click on “My Documents.” Your screen will now indicate that you are copying these files to your “My Documents” location in your computer which is your ‘C’ drive. You then need to go to the top of your screen and click on “Edit” and then click on “Paste.” You should then see your screen change showing the various files being copied onto your computer. You can exit the Windows Explorer feature by clicking on “x” at the top right of the computer monitor screen or by clicking on “File” then “Close.” To verify that all of the files have copied, get into your “Microsoft Word” program and open each of the files. If you see “READ ONLY” at the top of the screen, you need to read section 4 instructions to fix the setting on your computer to change these files so you can make changes to the files.

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QUIRKS WITH MS WORD WHEN COPYING FILES AND USING THE “SAVE AS” FEATURE TO RENAME FILES. Dr Nordhoff only uses the Arial or Times New Roman fonts in the files. Sometimes Microsoft Word will preset defaults to the Calibri font when you cut and paste or copy a file. Get rid of any Calibri fonts. If you notice an abnormal gap in the rows or sentences after copying/pasting material in these files, put cursor where problem exists and block it, then click on “Page Layout” Look for “Spacing” they should all read “0 pt” and if not make the change.

When desiring to use a portion or to make new versions of a file, it is best open the desired file, then click on the “File” or “Office Button” then click on the “Save As” feature, then rename file making certain to keep the file in “My Documents,” then delete everything you do not want in the file, leaving just the material that is desired. This process is less problematic overall and will save the margins, font sizes and the file format.

THE DOCTOR’S AND PATIENT NAME AS WELL AS DATE SHOULD BE ON EVERY PAGE ON INTAKE FORMS. USE « REPLACE » FEATURE TO MAKE CHANGES EASILY BEFORE PRINTING.